



Affidavit of Domestic Partnership

(For Coverage Effective in 2009 Only)

This form should only be used to apply for domestic partner coverage effective prior to January 1, 2010 for the following plans that currently offer domestic partner coverage:

- Anthem DentalBlue Dental Insurance
- OptumHealth Vision Insurance
- Individual and Family Group Life Insurance
- Accidental Death & Dismemberment Life Insurance

DO NOT USE THIS FORM to apply for domestic partner coverage under State Group Health Insurance or for any coverage effective January 1, 2010 or later. You must complete the Affidavit of Domestic Partnership (ET-2371) provided by the Department of Employee Trust Funds to establish a domestic partnership for health insurance purposes. This form is available online at: www.etf.wi.gov/publications/et2371.pdf.

Employee Information

Name: _____ Soc. Sec. Number: _____

Daytime Phone Number: _____

Home Phone Number: _____

Residence Address: Street: _____

City: _____ State: _____ Zip: _____

Domestic Partner Information

Name: _____ Soc. Sec. Number: _____

Daytime Phone Number: _____

Declaration

We, the undersigned _____ and _____
(Employee's Name) (Partner's Name)

declare that on _____ we agreed to live as domestic partners in a
(Insert Date)

committed relationship of mutual support and caring and that we have so lived since that time. We further state that since that time we have held ourselves out publicly to be each other's sole domestic partner and intend to remain in such a committed relationship for the foreseeable future. By our signatures on this Affidavit, we hereby certify that we meet all of the requirements listed in the following definition of **Domestic Partner**.

DOMESTIC PARTNERS are defined as two individuals who, together, each meet all of the following criteria:

1. Are 18 years of age or older.
2. Are competent to enter into a contract.
3. Are not legally married to, nor the domestic partner of, any other person.
4. Are not related by marriage.
5. Are not related by blood closer than permitted under marriage laws of the State of Wisconsin.
6. Have entered into the domestic partner relationship voluntarily, willingly and without reservation.
7. Have entered into a relationship which is the functional equivalent of a marriage, and which includes all of the following:
 - o living together as a couple;
 - o mutual support of each other;
 - o mutual caring and commitment to each other;
 - o mutual fidelity;
 - o mutual responsibility for each other's welfare; and
 - o joint responsibility for the necessities of life.
8. Have been living together as a couple for at least six (6) months prior to registration with the Subscriber's employer.
9. Intend to continue the domestic partner relationship indefinitely, with the understanding that the relationship is terminable at the will of either partner.

Change in Domestic Partner Status

We agree to notify the University by filing a Statement of Termination if there is any change in our status as domestic partners as attested to in this Affidavit. After termination of this relationship, we understand that a subsequent Affidavit of Domestic Partnership cannot be filed for at least 6 months.

Acknowledgments

We have provided the information in this Affidavit for use by the University for the sole purpose of determining eligibility for Domestic Partner benefits. We understand that we are subject to the same enrollment requirements as all other employees who are covered by, or applying for, the same plan.

We have read and understand the provisions of this Domestic Partner Affidavit. We acknowledge and agree to the terms stated herein and we understand that any misrepresentation may result in loss of benefits and/or termination of employment. We agree that false, inaccurate, or misleading information may result in the payment of unauthorized benefits, and may result in legal, financial, and other penalties as provided by law for which we are responsible. We further understand that if the Insurer suffers any loss due to any false statement contained in this Affidavit, it may bring a civil action against either or both of us to recover its losses, including reasonable attorney's fees.

The Insurer retains the right to verify, at any time, any and/or all of the information set forth herein. We have reviewed information we have provided and do hereby certify that it is true and correct to the best of our knowledge.

Employee Signature _____ Date _____

Partner Signature _____ Date _____